DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2002 — 17

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 1/1/03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.10 and 482

7. FEDERAL BUDGET IMPACT: **1/03-9/03
a. FFY 2003** $ 1483
b. FFY 2004 $ 1980

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-E, page 1
Attachment 3.1-F
Supplement 1, pages 19, 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-E, page 1
Attachment 3.1-F
Supplement 1, pages 19, 20

10. SUBJECT OF AMENDMENT:
Adult Lung Transplant Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: will be submitted when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive MS#20
Tallahassee, FL 32308
ATTN: Wendy Johnston

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
January 10, 2003

18. DATE APPROVED:
February 20, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Rhonda R. Cottrell

21. TYPED NAME:
Rhonda R. Cottrell

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

State/Territory: FLORIDA

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

For children under age 21, Florida covers organ transplants that are medically necessary and appropriate. For recipients age 21 and older, Florida covers kidney, liver, cornea, heart, lung, and bone marrow transplants that are medically necessary. An exception is that Medicaid covered emergency services for undocumented aliens, illegal aliens and legal non-immigrants do not include care and services related to organ transplant procedures. An adult heart transplant procedure requires prior-authorization. Other transplant procedures performed at approved transplant hospitals in Florida do not require prior authorization from the Medicaid office. All out-of-state transplants and evaluations require prior authorization.

Prior authorization is requested using the Florida Medicaid Authorization Request Form to which must be attached documentation by the transplant team, indicating that the recipient is a suitable transplant candidate. The medical consultants within the Medicaid office base their determination regarding prior authorization on the recommendation made by the transplant team, and documentation submitted. Each transplant team maintains its own criteria for determining whether an eligible Medicaid recipient may be considered for suitability as a transplant candidate.

Organ transplants for Florida Medicaid recipients are restricted to organ transplant hospitals that meet Medicare participation requirements of 42 CFR 440.10 and 482 and are approved by the Director of the Agency for Health Care Administration (AHCA) upon the recommendation of the Organ Transplant Advisory Council (FS 381.0602) as a designated Medicaid transplant facility. The Organ Transplant Advisory Council and AHCA approve the standards by which the transplant hospitals are evaluated and selected. These standards, which specify the qualifications of the facility and medical staff for each approved transplant hospital, are provided in Attachment 3.1-E, Supplement I.

Post transplant services are payable as long as they are medically necessary, covered under Medicaid and included in the State Plan. Coverage for post-transplant services begins once the transplant recipient has been discharged from the inpatient hospital. Post transplant services include any medically necessary physician, outpatient, inpatient, laboratory, pharmacy and radiology services.
All other program limitations apply.

GUIDELINES FOR THE

LUNG TRANSPLANTATION PROGRAM

In addition to the requirements recommended for the designation of an End-Stage Disease and Organ-Tissue Transplantation Hospital, the following guidelines are to be required of the Lung Transplantation Program.

1. Lung transplantation must be provided in a medical facility with:

   a) An established Pediatric and Adult Pulmonary and Cardiopulmonary Surgery Program.

   b) Pathology resources for (1) studying and promptly reporting the responses in transplantation and (2) performing and analyzing pulmonary tissue biopsies.

   c) Standard surgical units.

   d) A minimum of one-bed isolation room in an age-appropriate adult or pediatric intensive care unit.

   e) Blood Banking facilities.

2. Program personnel must include:

   a) Staffing specified in the approved transplant hospital requirements that have training and expertise in caring for adult and/or pediatric pulmonary patients who are candidates for, and recipients of, lung transplantation.

   b) Identified personnel who are integrated into a comprehensive team with defined leadership and responsibilities.

   c) Board-certified pediatric and adult pulmonologists who have an active clinical program.

   d) Anesthesiologists experienced in both cardiopulmonary surgery and lung transplantation.

3. Lung transplantation is reserved for patients with end-stage pulmonary disease, either congenital or acquired, for whom there are no standard medical or surgical therapies available.

NEW
TN No. 2002-17
Effective: 1/1/03
Approval Date: 2/20/03

4. Patient selection criteria for lung transplantation may include those:

a) With primary pulmonary disease or irreparable lung disease.

b) With poor prognosis, i.e. less than 10-25% chance of survival for twelve to eighteen months as a result of poor pulmonary functional status.

c) In which other medical and surgical therapies have been considered or tried but would not yield an improvement and a one-year survival comparable to that of lung transplantation.

d) With families who will be capable of following a complex medical program for the rest of the patient's life following transplantation.

e) Who have had a thorough clinical, social, and psychological evaluation as a candidate for transplantation.

f) Who have been presented to a Clinical Review Board of the Lung Transplantation Program for decision regarding suitability as a candidate.